Guiding Eyes for the Blind
Vision Assessment Form
(To be completed by eye care professional)

THIS FORM DOES NOT NEED TO BE COMPLETED IF YOU ARE A RETURNING GRADUATE

Patient’s Name:______________________________________________________________

Date of Most Recent Exam:____________________________________________________

Cause of Vision Loss:________________________________________________________

When did vision loss occur? □ Birth  □ Juvenile  □ Adolescent  □ Adult

If multiple occurrences or causes, please explain:

___________________________________________________________________________

Acuity: __________

Field vision: __________

Please choose the best description of the client’s visual status:

**R eye**- □ None    □ High partial    □ Low partial    □ Shadows    □ Hand motion @__ ft.    □ Light perception
□ Other: ______________________

**L eye**- □ None    □ High partial    □ Low partial    □ Shadows    □ Hand motion @__ ft.    □ Light perception
□ Other: ______________________

Prognosis: _________________________________________________________________

*Is client legally blind?* □ Yes □ No

Ocular medications: __________________________________________________________

**COMMENTS:**

Signature: ___________________________________________  M.D./D.O./O.D.  Address: __________________________

(Please type or print name)

Date: ___________________________  Telephone No. ________________

Fax No. ___________________________